Kansas
## Department for Aging and Disability Services

Course 7: SHICK Annual Update On-line Training

2015 Web-Based Extended Training

Study Directions

- This training will complete the required 12 hours of Annual Update Training for the 2015 SHICK grant year for experienced SHICK Counselors, along with the 2015 Session 6 training you have already completed.
- This course is available for on-line study or by printing the PDF formatted document.
- You are expected to study this course and then complete the available test. Instructions on using the test are at the end of this training course.
- This is a searchable document, using the find function in Adobe.
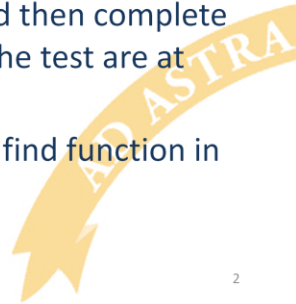
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SHICK Annual Update On-line Training Objectives

- The information for this training session was obtained from multiple sources referenced at the end of the presentation.
- The focus of this training will be to:
  - Medicare Access and CHIP Reauthorization Act (MACRA) Medicare Provisions
  - Medicare Improvements for Patients and Providers Act (MIPPA)
  - Health Insurance Portability and Accountability Act (HIPAA)
  - SHICK Counselor Information
  - Moving From Affordable Care Act (ACA) to Medicare
  - Moving From Employer Health Coverage to Medicare
  - Long-Term Care (LTC) Payment Options and Insurance
  - Quality Improvement Organizations (QIOs)
  - CMS Program Resources

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Medicare Access and CHIP Reauthorization Act (MACRA) Medicare Provisions

Medicare Improvements for Patients and Providers Act (MIPPA)

Health Insurance Portability and Accountability Act (HIPAA)

SHICK Counselor Information

Moving From Affordable Care Act (ACA) to Medicare

Moving From Employer Health Coverage to Medicare

Long-Term Care (LTC) Payment Options and Insurance

Quality Improvement Organizations (QIOs)

CMS Program Resources

Medicare Access and CHIP Reauthorization Act (MACRA) Medicare Provisions

- Sustainable Growth Rate (SGR) Repeal and Medicare Provider Payment
- Medicare and Other Health Extenders
- Savings to Medicare and Medicaid programs
- Protecting the Integrity of Medicare Act of 2015 (PIMA)
- Prohibition of Inclusion of Social Security Numbers on Medicare Cards
- Income-related Premium Adjustment for Parts B and D
- Medigap (Medicare Supplement Insurance) Policy Changes

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Sustainable Growth Rate (SGR) Repeal and Medicare Provider Payment

Medicare and Other Health Extenders

Savings to Medicare and Medicaid programs

Protecting the Integrity of Medicare Act of 2015 (PIMA)

Prohibition of Inclusion of Social Security Numbers on Medicare Cards

Income-related Premium Adjustment for Parts B and D

Medigap (Medicare Supplement Insurance) Policy Changes

Prohibition of Inclusion of Social Security Numbers on Medicare Cards

- As part of the Medicare Access and CHIP Reauthorization Act of 2015 bill signed in April 2015, Social Security Numbers will be removed from Medicare Cards.
- Congress provided $320 million over four years to pay for the change.
- Medicare officials have up to four years to start issuing cards with new identifiers (cards starting in 2019).
- They will have four more years to reissue cards held by current beneficiaries.
- The new Medicare Beneficiary Identifier (MBI) will be
  - Recognizably different than the Medicare Health Insurance Claim Number (HICN)
  - The same length as the HICN
  - Displayed on the Medicare cards
  - Will be used by external partners (Beneficiary, Provider, Plans, etc.) participating in claims processing and other related activities when interacting with CMS

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SGR Repeal and Medicare Provider Payment Modernization

- Provisions to replace the Sustainable Growth Rate (SGR) formula to provide long-term stability to the Medicare physician fee schedule
- Provides stable updates for 5 years and ensures no changes are made to the current payment system for 4 years
- Establishes a streamlined and improved incentive payment program that will focus the fee-for-service system on providing value and quality
- Consolidates the 3 existing incentive programs, continuing the focus on quality, resource use, and meaningful electronic health records (EHRs)
- Provides financial incentive(s) for professionals to participate in tests of alternative payment models (APMs)

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Medicare and Other Health Extenders

- Extends increased payments for certain low-volume and small rural hospitals, doctors, therapy services, and ambulance providers
  - Through either fiscal year 2017 or calendar year 2017
  - Depending on Medicare's payment system to that type of provider
- Extension of therapy cap exceptions process
  - Until January 1, 2018, and reforms the process of medical manual review to help support the integrity of the Medicare program
- Extension for specialized Medicare Advantage (MA) Plans for special needs individuals (Special Needs Plans)
  - This provision extends authority for SNPs through December 31, 2018
- Permanent extension of the Qualifying Individual (QI) program
  - As part of the Medicare Savings program, the QI program provides Part B premium assistance for individuals between 121% and 135% FPL.

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Permanent extension of the Qualifying Individual (QI) program

As part of the Medicare Savings program, the QI program provides Part B premium assistance for individuals between 121% and 135% FPL.

Savings to Medicare and Medicaid Programs

- Significant provisions include
    - Higher income thresholds starting in 2018 for determining Part B and Part D premium subsidies
        - Beginning in 2020, more people will pay higher Part B and Part D premiums due to a change in the indexing of income thresholds
    - Payment rate in 2018 for skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, hospices and long-term care hospitals would be limited to 1%
    - Planned 3.2% increase in inpatient hospital payment rate replaced by 0.5% increase each year from 2018-2023

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Income-related Premium Adjustment for Parts B and D

Modified Adjusted Gross Income Threshold for Years Prior to 2018	Modified Adjusted Gross Income Threshold for Years Beginning in 2018	Applicable Percentage
More than $85,000 but not more than $107,000	More than $85,000 but not more than $107,000	35%
More than $107,000 but not more than $160,000	More than $107,000 but not more than $133,500	50%
More than $160,000 but not more than $214,000	More than $133,500 but not more than $160,000	65%
More than $214,000	More than $160,000	80%

Beginning in 2020, the income thresholds would be adjusted each year by increasing the previous year's income threshold amounts by the consumer price index for urban consumers.

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Income-related Premium Adjustment for Parts B and D

Protecting the Integrity of Medicare

- Strengthening Medicare's ability to fight fraud and build on existing program integrity policies
  - Prohibiting Social Security numbers on Medicare cards (no later than 4 years after enactment)
  - Preventing payments for items and services furnished to incarcerated individuals, individuals not lawfully present, and deceased individuals
  - Modifying Medicare Durable Medical Equipment Face-to-Face Encounter Documentation Requirement
  - Requiring Valid Prescriber National Provider Identifiers on Pharmacy Claims (starting plan year 2016)
  - Option to Receive Medicare Summary Notice Electronically (starting in Fall of 2017)
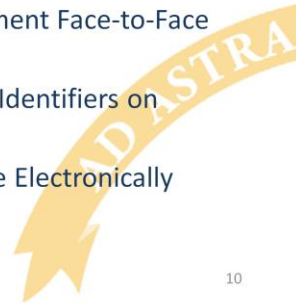
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Medigap (Medicare Supplement Insurance) Policy Changes

- Limitation on certain Medigap policies for people newly eligible for Medicare
  - On or after January 1, 2020
  - Medigap policies sold to newly eligible Medicare beneficiaries
    - Will no longer provide coverage for the Part B deductible
- Newly eligible means an individual who, before January 1, 2020, is neither 65, nor has Part A
- Plans C and F will become Plans D and G respectively for policies sold to those newly eligible
  - Policies bought before January 1, 2020, won't be affected

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Medicare Improvements for Patients and Providers Act (MIPPA)

- The MIPPA grant for this year ends in September
- New MIPPA Program Coordinator – Dawn Turner
- MIPPA - Under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), states, territories, and the District of Columbia received funding to help Medicare beneficiaries apply for the Medicare Part D Extra Help/Low-Income Subsidy (LIS) and the Medicare Savings Programs (MSPs).
  - Funding is used to provide Part D counseling to Medicare beneficiaries who live in rural areas, and to promote the new Medicare prevention and wellness benefits.

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Funding is also used to provide Part D counseling to Medicare beneficiaries who live in rural areas, and to promote the new Medicare prevention and wellness benefits.

Medicare Improvements for Patients and Providers Act (MIPPA)

- Since 2008, MIPPA provides targeted funding for SHIPs, AAAs, and ADRCs to:
  - Conduct outreach and enrollment of low-income Medicare beneficiaries into Part D Low Income Subsidy (LIS/Extra Help) and the Medicare Savings Programs (MSPs).
  - Help rural residents to enroll in Part D.
  - Promote utilization of free preventive services offered under Medicare since the passage of the Affordable Care Act (ACA) in 2010.
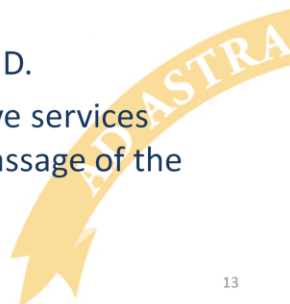
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Medicare Improvements for Patients and Providers Act (MIPPA) cont.

- In 2014, 44 states and the District of Columbia applied for MIPPA IV funding from ACL.
- Title VI Native American Programs were invited to apply to coordinate at least one community announcement and one outreach event to inform and assist eligible American Indian, Alaska Native, or Native Hawaiian elders about benefits available through Medicare.
- 91 Tribes in 17 states (AK, AZ, CA, ID, KS, ME, MI, MN, MT, NM, NV, NY, OK, OR, SD, WA, WI) received funding.

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Medicare Improvements for Patients and Providers Act (MIPPA) cont.

- Target populations:
  - More than half of the states include American Indians/Native Alaskans. Outreach strategies include liaising with tribal councils and targeting tribal media outlets. At least 3 states will conduct outreach through powwows.
  - Technology is key in reaching rural populations. Skype counseling, bringing tablets into remote areas, and tele-Town Hall meetings are other ways to connect with rural residents.
  - Other target populations include: Limited English Proficient (LEP) beneficiaries, veterans, the homeless, and homebound individuals.
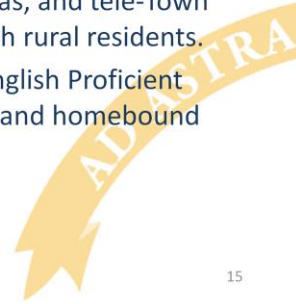
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Medicare Improvements for Patients and Providers Act (MIPPA) cont.

- Key partnerships: health care providers; religious, ethnic, and communication organizations; State Pharmaceutical Assistance Programs; and Centers for Independent Living are partners working with SHIPs, AAAs, and ADRCs to do outreach and enrollment. Some states:
    - Partner with local Social Security Administration (SSA) offices by co-hosting "Welcome to Medicare" events, and posting information to get assistance through the aging network;
    - Partner with providers and community mental health agencies to better reach persons with mental illness and behavioral health issues; and
    - Help ease the transition individuals aging into Medicare from the health insurance marketplace.

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Medicare Improvements for Patients and Providers Act (MIPPA) cont.

- Collaboration with health initiatives:
  - Many low-income Medicare beneficiaries have a chronic condition. Some states collaborate with Chronic Disease Self-Management Education (CDSME) programs by referring clients to SHIPs, AAAs, and ADRCs for more information about Medicare cost savings and providing materials to that outline the preventive services offered by Medicare to keep them healthy.
  - Some states have partnerships with Federally Qualified Health Centers (FQHCs), which provide primary health care services to underserved communities.
- Since 2009, SHIPs, AAAs, and ADRCs have submitted more than 860,000 applications for LIS and MSP, worth a combined $2.3 billion in benefits.

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MIPPA Reminders

- More information: http://www.ncoa.org/enhance-economic-security/center-for-benefits/mippa/
- Make sure all beneficiaries seen by SHICK are screened for Extra Help and MSP.
- During a comprehensive counseling appointment be certain to hand out information about Medicare Preventive Services.
  - Talk to the beneficiary about www.mymedicare.gov
- Make sure you are recording your contacts including low-income Medicare beneficiaries
- MIPPA indicators from SHIP NPR:
  - 1 - LIS　　　2 – MSP　　3 – both LIS and MSP

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Health Insurance Portability and Accountability Act (HIPAA)

- What is HIPAA?
  - HIPAA- Health Insurance Portability and Accountability Act – 1996
- HIPAA Privacy Rule
  - The Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

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What is HIPAA?

HIPAA- Health Insurance Portability and Accountability Act – 1996

HIPAA Privacy Rule

The Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

HIPAA Privacy Rule

- Why the HIPAA Privacy Rule is needed
  - prior to adoption of HIPAA and the Privacy Rule, personal health information could be distributed—without either notice or authorization—for reasons that had nothing to do with a patient's medical treatment or health care reimbursement.
  - With information broadly held and transmitted electronically, the Rule provides clear standards for the protection of personal health information.

In enacting HIPAA, Congress mandated the establishment of Federal standards for the privacy of individually identifiable health information. When it comes to personal information that moves across hospitals, doctors' offices, insurers or third party payers, and State lines, we relied on a patchwork of Federal and State laws. Under the patchwork of laws existing prior to adoption of HIPAA and the Privacy Rule, personal health information could be distributed—without either notice or authorization—for reasons that had nothing to do with a patient's medical treatment or health care reimbursement. For example, unless otherwise forbidden by State or local law, without the Privacy Rule patient information held by a health plan could, without the patient's permission, be passed on to a lender who could then deny the patient's application for a home mortgage or a credit card, or to an employer who could use it in personnel decisions. The Privacy Rule establishes a Federal floor of safeguards to protect the confidentiality of medical information. State laws which provide stronger privacy protections continue to apply over and above the Federal privacy standards.

Health care providers have a strong tradition of safeguarding private health information. However, in today's world, the old system of paper records in locked filing cabinets is not enough. With information broadly held and transmitted electronically, the Rule provides clear standards for the protection of personal health information.

Who Must Follow the HIPAA Privacy Rule

- Entities that must follow the Privacy Rule are "*covered entities*." Covered entities include:
  - Health Plans
  - Most Health Care Providers
  - Health Care Clearinghouses
  - Hybrid Entities
    - A single legal entity where only some of the divisions or programs meet the definition of a Covered Entity.
    - KDHE and KDADS are examples of Hybrid Entities

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Who Must Follow the HIPAA Privacy Rule

We call the entities that must follow the Privacy Rule "*covered entities*." Individuals, organizations, and agencies that met the definition of a covered entity under HIPAA must comply with the Privacy Rule's requirements to protect the privacy of health information and must provide individuals with certain rights with respect to their health information. If an entity is not a covered entity, it does not have to comply with the Privacy Rule.

Covered entities include:

- **Health Plans**, including health insurance companies, HMOs, company health plans, and certain government programs that pay for health care, such as Medicare and Medicaid.
- **Most Health Care Providers**—those that conduct certain business electronically, such as electronically billing your health insurance—including most doctors, clinics, hospitals, psychologists, chiropractors, nursing homes, pharmacies, and dentists.
- **Health Care Clearinghouses**—entities that process nonstandard health information they receive from another entity into a standard (i.e., standard electronic format or data content), or vice versa.
- **Hybrid Entities**
  - A single legal entity where only some of the divisions or programs meet the definition of a Covered Entity.
  - KDHE and KDADS are examples of Hybrid Entities

Who Is Not Required to Follow This Law

- Many organizations that have health information about you do not have to follow this law.
- Examples of organizations that do not have to follow the Privacy Rule include:
  - life insurers,
  - employers,
  - workers compensation carriers,
  - many schools and school districts,
  - many state agencies like child protective service agencies,
  - many law enforcement agencies,
  - many municipal offices.

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What Information Is Protected

- Information your doctors, nurses, and other health care providers put in your medical record
- Conversations your doctor has about your care or treatment with nurses and others
- Information about you in your health insurer's computer system
- Billing information about you at your clinic
- Most other health information about you held by those who must follow this law

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How Is This Information Protected

- Covered entities must:
  - put in place safeguards to protect health information.
  - reasonably limit uses and disclosures to the minimum necessary to accomplish their intended purpose.
  - have contracts in place with their contractors and others ensuring that they use and disclose health information properly and safeguard it appropriately.
  - have procedures in place to limit who can view and access health information as well as implement training programs for employees about how to protect health information.

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Is a SHIP a covered entity? Is SHICK a covered entity?

- In general, a SHIP is not a covered entity. We do not:
  - bill or receive payment for health care in the normal course of business.
  - process, or facilitate the processing of, health information from nonstandard format or content into standard format or content or from standard format or content into nonstandard format or content.
  - provide, or pay for the cost of, medical care.
  - as the principal activity of the program provide health care directly.
  - participate in making of grants to fund the direct provision of health care (e.g., through funding a health clinic).
- **However, our program is part of a Hybrid entity and, as such, SHICK counselors are required to follow the HIPAA Privacy Rule regarding the PHI of Medicare Beneficiaries they assist.**

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Protecting Beneficiary Privacy

- As a SHICK counselor, you will have access to beneficiaries' health information as well as personal identifying information like Medicare numbers and Social Security Numbers.
- You must handle this information carefully and keep it confidential to protect beneficiaries from fraud, identity theft, health-based discrimination, and other potential problems.

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Protecting Beneficiary Privacy

As a SHICK counselor, you will have access to beneficiaries' health information as well as personal identifying information like Medicare numbers and Social Security Numbers. You must handle this information carefully and keep it confidential to protect beneficiaries from fraud, identity theft, health-based discrimination, and other potential problems.

- Only collect the information you need to provide the help the beneficiary has asked for (for example, you don't need a list of medications to help someone enroll in a Medigap plan).
- Only share beneficiary information with people or agencies who are directly involved in providing the help the beneficiary has asked for (like a Part D plan, for example).
- Don't keep beneficiary information on a laptop or in a file that you take out of the office with you.
- Don't leave beneficiary information out on a desk or up on a computer screen where it can be seen by others.
- Conduct counseling sessions in private where personal information shared by the beneficiary won't be overheard by others.
- If you believe beneficiary information has been lost, stolen, or misused, contact your SHICK Coordinator immediately.
- If you believe a beneficiary has been the victim of fraud or identity theft, contact your SHICK Coordinator and/or the Kansas SMP Coordinator immediately.

SHICK Counselor Information

- Report on the SHIPNPR website at
  https://shipnpr.acl.gov/
  - All of activities for the month, including client contacts and public & media events.
- Due on the last day of the month following the month of contact

Remember: If you do not report a client contact, *then it never happened*. The Kansas SHICK program receives our funding via the national SHIP program.

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Moving From the Marketplace to Medicare

- If you have Medicare, you do not need to do anything related to the Marketplace
    - Your benefits do not change because of the Marketplace
- Medicare is not part of the Marketplace
- Medicare Part A is considered minimum essential coverage
    - Medicare Part B only does not meet the requirement for minimum essential coverage
- The Marketplace does not offer:
    - Medicare Supplement Insurance (Medigap) policies
    - Medicare Prescription Drug Plans (Part D)

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The Marketplace does not offer:
-Medicare Supplement Insurance (Medigap) policies
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If You Have Medicare

- No one can sell you a Marketplace plan
  - Even if you only have Medicare Part A or Part B.
  - Except an employer through the Small Business Health Options Program (SHOP) if you are an active worker of dependent of an active worker.
    - The size of the employer helps determine who pays first.
    - No late enrollment penalty if you enroll anytime you have SHOP coverage, or within 8 months of losing that coverage.
    - Doesn't include COBRA coverage.

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No one can sell you a Marketplace plan

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- Doesn't include COBRA coverage.

Marketplace and Becoming Eligible for Medicare

- Sign up for Medicare during your Initial Enrollment Period (IEP)
    - The 7-month period that starts 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.
    - If you enroll later, you may have to pay a late enrollment penalty
        - ❑ For as long as you have Medicare

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If You Have a Marketplace Plan First and Then Get Medicare Coverage

- You lose eligibility for any premium tax credits and/or reduced cost sharing for your Marketplace plan
- If you choose to drop your Marketplace plan, wait until you are covered by Medicare to avoid a gap in coverage
  - Depending on your income and resources, you may be eligible for help paying your Medicare Part B and Part D premiums and for some reduced cost sharing for Medicare Part D coinsurance/
    copayment.
  - You may also be able to buy a Medigap (Medicare Supplement Insurance) policy or join a Medicare Advantage Plan (like an HMO or PPO)
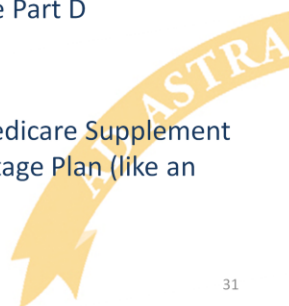
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If You Have a Marketplace Plan First and Then Get Medicare Coverage

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If you choose to drop your Marketplace plan, wait until you are covered by Medicare to avoid a gap in coverage

- Depending on your income and resources, you may be eligible for help paying your Medicare Part B and Part D premiums and for some reduced cost sharing for Medicare Part D coinsurance/
  copayment.
- You may also be able to buy a Medigap (Medicare Supplement Insurance) policy or join a Medicare Advantage Plan (like an HMO or PPO)

Choosing Marketplace Instead of Medicare

- If you have an individual Marketplace plan
  - And you must pay a premium for Part A, you would need to drop Part A and Part B to be eligible to get a Marketplace plan.
  - However, if you are also receiving Social Security benefits, you would have to drop your Social Security if you drop Medicare
- If you delay enrolling in Medicare after your Initial Enrollment Period (IEP) ends, a late enrollment penalty may apply.
  - You would only be able to enroll during the Medicare General Enrollment Period (January 1 to March 31, coverage starting July 1)
  - Pay a late enrollment penalty for as long as you have Medicare.

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Choosing Marketplace Instead of Medicare

If you have an individual Marketplace plan

- And you must pay a premium for Part A, you would need to drop Part A and Part B to be eligible to get a Marketplace plan.
- However, if you are also receiving Social Security benefits, you would have to drop your Social Security if you drop Medicare

If you delay enrolling in Medicare after your Initial Enrollment Period (IEP) ends, a late enrollment penalty may apply.

- You would only be able to enroll during the Medicare General Enrollment Period (January 1 to March 31, coverage starting July 1)
- Pay a late enrollment penalty for as long as you have Medicare.

Terminating Medicare for Marketplace Plan

- If you are enrolled in premium Part A and Part B, or Part B only
  - You can disenroll from Medicare and choose a Marketplace plan
  - You can qualify for advanced premium tax credit (APTC) or cost sharing reduction (CSR) if you meet eligibility requirement.
- Enrolled in Medicare premium free Part A
  - Must withdraw the application for Social Security benefits
  - Pay back all Social Security and Medicare benefits received
  - Lose APTC and CSR

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Terminating Medicare for Marketplace Plan
If you are enrolled in premium Part A and Part B, or Part B only
- You can disenroll from Medicare and choose a Marketplace plan
- You can qualify for advanced premium tax credit (APTC) or cost sharing reduction (CSR) if you meet eligibility requirement.
Enrolled in Medicare premium free Part A
- Must withdraw the application for Social Security benefits
- Pay back all Social Security and Medicare benefits received
- Lose APTC and CSR

Medicare for People with Disabilities and the Marketplace

- You may qualify for Medicare based on a disability
  - You must be entitled to Social Security Disability Insurance (SSDI) benefits for 24 months
    - ❑ On the 25th month, you are automatically enrolled in Medicare Part A and B
- If you are getting SSDI, you can get a Marketplace plan to cover you during your 24-month waiting period
  - You may qualify for Medicaid or premium tax credits and reduced cost-sharing until your Medicare coverage starts

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Medicare for People with Disabilities and the Marketplace
You may qualify for Medicare based on a disability
- You must be entitled to Social Security Disability Insurance (SSDI) benefits for 24 months
  - On the 25th month, you are automatically enrolled in Medicare Part A and B

If you are getting SSDI, you can get a Marketplace plan to cover you during your 24-month waiting period
- You may qualify for Medicaid or premium tax credits and reduced cost-sharing until your Medicare coverage starts

Medicare and Coverage Through the Small Business Health Options Program (SHOP)

- Medicare Secondary Payer rules apply
- You may delay your Part B enrollment while covered by the Marketplace through you or your spouse's current employment
- You will have a Special Enrollment Period (SEP) to sign up for Part B
    - Any time you are still covered by a group plan through you/your spouse's current employment
    - During 8-month period after current employment/coverage ends
- If you do not sign up for Part B during the SEP
    - You may have to pay a late enrollment penalty for as long as you have Medicare
    - You can only enroll during the General Enrollment Period
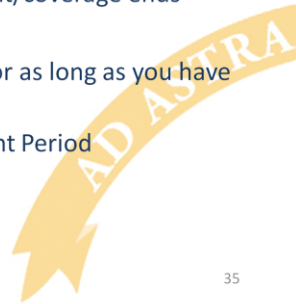
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Medicare and Coverage Through the Small Business Health Options Program (SHOP)

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You may delay your Part B enrollment while covered by the Marketplace through you or your spouse's current employment

You will have a Special Enrollment Period (SEP) to sign up for Part B

- Any time you are still covered by a group plan through you/your spouse's current employment
- During 8-month period after current employment/coverage ends

If you do not sign up for Part B during the SEP

- You may have to pay a late enrollment penalty for as long as you have Medicare
- You can only enroll during the General Enrollment Period

The Marketplace and…

- Medicare prescription drug coverage (Part D)
  - Prescription drug coverage in Marketplace plans (including SHOP) is not required to be creditable
    - ❑ Plan is required to let you know each year, in writing
    - ❑ You may have to pay a late enrollment penalty for Part D if you enroll after your Initial Enrollment Period and have not had creditable drug coverage since first eligible for Medicare (any 63 day gap in creditable coverage)
- Dental coverage for adults
  - Covered by some Marketplace plans
  - Stand-alone dental plans
    - ❑ People with Medicare generally cannot join a stand-alone Marketplace dental plan unless in a State-based Marketplace and the state allows you to join (check with your state)

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The Marketplace and…

Medicare prescription drug coverage (Part D)

-        Prescription drug coverage in Marketplace plans (including SHOP) is not required to be creditable

  ❑   Plan is required to let you know each year, in writing

  ❑   You may have to pay a late enrollment penalty for Part D if you enroll after your Initial Enrollment Period and have not had creditable drug coverage since first eligible for Medicare (any 63 day gap in creditable coverage)

Dental coverage for adults

-        Covered by some Marketplace plans

-        Stand-alone dental plans

  ❑   People with Medicare generally cannot join a stand-alone Marketplace dental plan unless in a State-based Marketplace and the state allows you to join (check with your state)

Check Your Knowledge – Scenario 1

Jim has Medicare Part A only. He did not enroll in Part B during his Initial Enrollment Period (IEP). He signed up for Part B in January 2015, during the General Enrollment Period, and his coverage will begin on July 1.

Could he have enrolled in a Marketplace plan while he waited for his Part B to take effect?

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Check Your Knowledge – Scenario 1

Jim has Medicare Part A only. He did not enroll in Part B during his Initial Enrollment Period (IEP). He signed up for Part B in January 2015, during the General Enrollment Period, and his coverage will begin on July 1.

Could he have enrolled in a Marketplace plan while he waited for his Part B to take effect?

Scenario 1 - Discussion

No. Medicare Part A is considered minimum essential coverage. Jim could not get a Marketplace plan since he already had minimum essential coverage.

Remember, it is illegal for anyone to sell you a Marketplace plan if you have Medicare.

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Check Your Knowledge – Scenario 2

Barbara works part-time and is not getting Social Security retirement benefits yet. Her employer does not offer health coverage, so she enrolled in a Marketplace plan. Her Medicare Initial Enrollment Period ends next month, but she decided to keep her Marketplace plan and wait to sign up for Medicare.

- Will Barbara have a late enrollment penalty when she signs up for Medicare Part B/
- What about Part D?
- What else should you tell her?
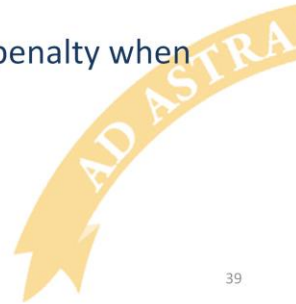
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Check Your Knowledge – Scenario 2

Barbara works part-time and is not getting Social Security retirement benefits yet. Her employer does not offer health coverage, so she enrolled in a Marketplace plan. Her Medicare Initial Enrollment Period ends next month, but she decided to keep her Marketplace plan and wait to sign up for Medicare.

> Will Barbara have a late enrollment penalty when she signs up for Medicare Part B/
> What about Part D?
> What else should you tell her?

Scenario 2 - Discussion

Barbara can choose Marketplace coverage if she is eligible for Medicare but has not enrolled in it (because she would have to pay a premium, or because she is not collecting Social Security benefits).

Before making this choice, there are two important points for Barbara to consider:

1. Generally she can enroll in Medicare **only** during the Medicare General Enrollment Period (from January 1 to March 31). Her coverage will not begin until July 1 of that year.
2. If she enrolls in Medicare after her Initial Enrollment Period ends, she may have to pay a late enrollment penalty for as long as she has Medicare.

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Scenario 2 – Discussion

Barbara can choose Marketplace coverage if she is eligible for Medicare but has not enrolled in it (because she would have to pay a premium, or because she is not collecting Social Security benefits).

Before making this choice, there are two important points for Barbara to consider:

1.   Generally she can enroll in Medicare **only** during the Medicare General Enrollment Period (from January 1 to March 31). Her coverage will not begin until July 1 of that year.

2.   If she enrolls in Medicare after her Initial Enrollment Period ends, she may have to pay a late enrollment penalty for as long as she has Medicare.

Scenario 2 – Discussion (cont.)

If her Marketplace plan's prescription drug coverage is not creditable, she may also have to pay a late enrollment penalty (LEP) for Medicare Part D coverage if she waits to enroll until after her Initial Enrollment Period.

Barbara should consider enrolling in Medicare to be sure she does not get an LEP for Part B and/or Part D. She can also choose to keep Marketplace coverage and also enroll in Medicare. In either case, Barbara will not be eligible for tax credits and there is no coordination of benefits. It is her choice.

Marketplace.cms.gov
Get the latest resources to help people apply, enroll, and get coverage.

Ways to Connect With the Marketplace

1. Sign up for updates at www.HealthCare.gov/subscribe/ or www.CuidadoDeSalud.gov/es/subscribe/
2. Twitter.com/HealthCareGov – Follow @HealthCareGov
3. Facebook.com/Healthcare.gov
4. Youtube.com/HealthCareGov
5. The Health Insurance Blog: www.HealthCare.gov/blog/
6. Federal training for agents and brokers, Navigators, in-person assisters, and Certified Application Counselors:
7. https://Marketplace.medicarelearningnetworklms.com
8. www.Facebook.com/Medicare.gov

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Ways to Connect With the Marketplace

1. Sign up for updates at www.HealthCare.gov/subscribe/ or www.CuidadoDeSalud.gov/es/subscribe/
2. Twitter.com/HealthCareGov – Follow @HealthCareGov
3. Facebook.com/Healthcare.gov
4. Youtube.com/HealthCareGov
5. The Health Insurance Blog: www.HealthCare.gov/blog/
6. Federal training for agents and brokers, Navigators, in-person assisters, and Certified Application Counselors:
7. https://Marketplace.medicarelearningnetworklms.com
8. www.Facebook.com/Medicare.gov

Moving from Employer Health Coverage to Medicare

- Insurance offered by your former employer (or a spouse's) once you retire.
- Medicare is always primary and your retiree plan is secondary.
- You are responsible for both Medicare's and retiree plan's premiums.
- Your former employer is not required to offer you the same coverage as when you were working.
- Your retiree benefits and premiums may change once you turn 65.

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Consider Your Options and Out-of-Pocket Costs:

- Which is more affordable and best suits your needs?
    - Medicare and your retiree plan **OR**
    - Medicare, Medigap, and a Part D plan, or Medicare Advantage plan
- Enrolling in Part B triggers your open enrollment period to buy a Medigap policy with guaranteed issue from any company (lasts 6 months).
- Does your retiree plan offer extra benefits not covered by Medicare?
- Are members of your family covered under your retiree plan?

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Does your retiree plan offer extra benefits not covered by Medicare?
Are members of your family covered under your retiree plan?

If You Have Retiree Coverage and Delay Enrolling in Part B…

- You will have to pay a Part B late enrollment penalty when you finally do decide to enroll.
  - 10% of the Part B premium for every full 12 months you were eligible but did not enroll
  - Penalty is for life and is not capped.
- Will only be able to enroll during the Part B General Enrollment Period (January 1 - March 31 each year, coverage begins July 1).
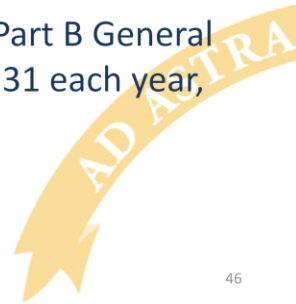
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Medicare and Multi-Employer Coverage

- Check with your plan's benefits administrator to find out how many people work for your company.
- Whether Medicare is primary or secondary depends on how many people work at your company and not how many are enrolled in the health plan.
- Sometimes employers with fewer employees come together and create a multi-employer plan.
- Offer the same coverage as larger companies.
- Makes a difference if Medicare is primary or secondary.
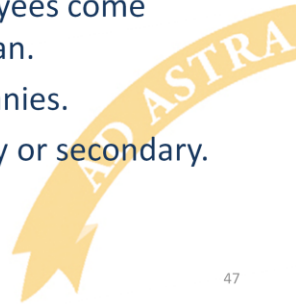
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If You Lose Your Job and Employer Coverage…

- Sign up for Part B and Part D as soon as possible.
- Part B: You have an 8-month special enrollment period (SEP) to enroll in Part B without penalty.
    - The sooner you enroll in Part B, the sooner your coverage beings.
    - Enrolling in Part B also triggers your 6-month Medigap open enrollment period.
    - Explore options for your dependents.
- Part D: You only have 63 days to enroll in Part D plan without penalty
    - Your plan will begin the first of the month following the month you enroll.

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-        Explore options for your dependents.
Part D: You only have 63 days to enroll in Part D plan without penalty
-        Your plan will begin the first of the month following the month you enroll.

Part D and Retiree Insurance

- If retiree plan offers prescription drug coverage, make sure it is creditable.
  - Ask your plan for a "Notice of Creditable Coverage".
- You will have 63 days to enroll in a Part D plan if your retiree prescription drug benefits come to an end.
  - Will not have a penalty as long as you enroll in a Part D plan within 63 days of losing your coverage.

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Long-Term Care (LTC) Payment Options & Insurance

- LTC is any form of help that an individual requires for taking care of basic activities of daily living (ADLs), such as bathing, eating, dressing, toileting, and transferring (walking).
- A person can receive LTC in different settings, not just a nursing home.
  - Home/Community-Based Settings
  - Adult Day Care and Social Day Care Programs
  - Home Health Agencies
  - Private Homes
  - Respite Centers
  - Facility-Based (LTC hospitals, skilled nursing facilities, nursing homes, adult foster care, personal care homes, assisted living residences, and Continuing Care Retirement Communities)

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-Home/Community-Based Settings

-Adult Day Care and Social Day Care Programs

-Home Health Agencies

-Private Homes

-Respite Centers

-Facility-Based (LTC hospitals, skilled nursing facilities, nursing homes, adult foster care, personal care homes, assisted living residences, and Continuing Care Retirement Communities)

Medicare & Long-Term Care

- Medicare pays more than 20% of the nation's total spending on long-term care services. It pays for more than a fourth of the home care that Medicare beneficiaries received.
- Medicare's coverage for LTC services is limited.
  - It covers skilled nursing care, LTC hospitals, and hospice care under Medicare Part A, and home health care under both Part A and Part B.
  - It does not pay for custodial level care if that is the only care that a beneficiary needs.

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Options for Long-Term Care

- Skilled Nursing Facility (SNF) Care
  - Medicare pays for 100 days in a benefit period.
  - Covers 100% of cost for first 20 days.
- Home Health Care
  - Medicare pays 100% for home health care for beneficiaries who are homebound and need rehabilitation care or skilled nursing services on a part-time or intermittent basis
- LTC Hospitals
  - Medicare has certified some facilities to operate as Long-Term Care hospitals. Average inpatient length of stay must be 25 days or longer.

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- **Skilled Nursing Facility (SNF) Care:** Medicare pays for 100 days in a benefit period. Covers 100% of cost for first 20 days. Beneficiary owes a coinsurance charge of $157.50 per day (in 2015) after the 21st day. To qualify for coverage in Original Medicare, the stay must follow an inpatient hospital stay of at least 3 days and beneficiary must receive skilled nursing or rehabilitation services on a daily basis.
- **Home Health Care:** Medicare pays 100% for home health care for beneficiaries who are homebound and need rehabilitation care or skilled nursing services on a part-time or intermittent basis. No limit on number of covered days for as long as the beneficiary remains homebound and receives a skilled service at least once in a 60-day period. Medicare also covers services of home health aides that help with some ADLs (such as bathing).
- **LTC Hospitals:** Medicare has certified some facilities to operate as LTC hospitals. Average inpatient length of stay must be 25 days or longer. They typically provide post-acute extended medical and rehabilitative care for patients whose conditions are complex and who may have more than one acute or chronic condition . Provided services are rehabilitation, respiratory therapy, cancer treatment, head trauma care, and pain management.

Long-Term Care Insurance (LTCI)

- Long-Term Care insurance is designed to help pay the costs of long-term care services that Medicare and other types of health insurance do not cover. It protects assets that a beneficiary would otherwise use to pay for long-term care.
- In Kansas, average cost in 2015 for a private room nursing home stay was $180 a day, or $65,700 a year.

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Who needs Long-Term Care Insurance (LTCI)?

- LTCI is geared toward middle-class, middle-aged individuals, whose assets could easily be exhausted in a one-year stay in a nursing home.
- A general rule is that if a person's annual income is more than $25,000 (single), and they have more than $80,000 in liquid assets, LTCI may be a cost-effective insurance option.
- Most companies will NOT sell LTCI to those who have potentially costly health problems.
- LTCI premiums increase with age at purchase.

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Most companies will NOT sell LTCI to those who have potentially costly health problems.
LTCI premiums increase with age at purchase.

Long-Term Care (LTC) Policies

- Several types of LTCI policies are available to consumers. Companies sell policies on an individual and group basis, often through employers.
- Most LTCI policies have common features. Consumers may be able to buy additional benefits, such as inflation protection.
- Insurers selling LTCI will screen applicants for existing medical conditions before issuing a policy.
- LTCI policies provide benefits according to an "Outline of Coverage" that summarizes a policy's key benefits, terms, and conditions.

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Several types of LTCI policies are available to consumers. Companies sell policies on an individual and group basis, often through employers.

Most LTCI policies have common features: conditions of coverage, daily payments, and a maximum benefit. Consumers may be able to buy additional benefits, such as inflation protection.

Insurers selling LTCI will screen applicants for existing medical conditions before issuing a policy. They set a premium based on a medical underwriting assessment that may include such factors as age, gender, lifestyle, and family history.

LTCI policies provide benefits according to an "Outline of Coverage" that summarizes a policy's key benefits, terms, and conditions. Consumers use Outlines of Coverage to compare benefits of two or more policies.

Long-Term Care (LTC) Policies Features

- **Benefit Triggers:** used to decide when a consumer is eligible to receive benefits
- **Pre-Existing Condition Waiting Period:** waiting period before a policy will pay for care related to a health condition that the consumer had when applying for the policy.
- **Plan of Care:** a document written by the consumer's health care providers that prescribes the LTC needed
- **Elimination, Deductible, or Waiting Periods:** amount of time a company waits to start benefit payments after a consumer's need
- **Exclusions:** certain medical, mental, or other conditions that an LTCI policy may not cover.
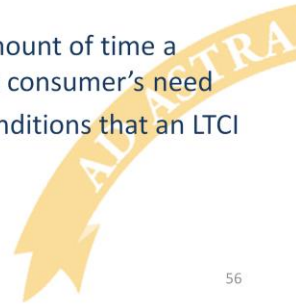
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- **Benefit Triggers:** used to decide when a consumer is eligible to receive benefits (an inability to perform ADLs, a cognitive impairment, a signed Certificate of Medical Necessity, prior hospitalization).
- **Pre-Existing Condition Waiting Period:** waiting period before a policy will pay for care related to a health condition that the consumer had when applying for the policy.
- **Plan of Care:** a document written by the consumer's health care providers that prescribes the LTC needed, including the (1) necessity of care, (2) type of care, and (3) frequency and length of care.
- **Elimination, Deductible, or Waiting Periods:** amount of time a company waits to start benefit payments after a consumer's need for LTC services "triggers" their eligibility for payments. Periods may last up to 100 days.
- **Exclusions:** certain medical, mental, or other conditions that an LTCI policy may not cover.

- **Daily Benefit Amount:** dollar amount a company will pay per day for covered services. The consumer is responsible for costs above that.
- **Duration of Benefits or Maximum Benefit Limit:** limit the total benefit they pay over the life of a policy (duration of benefits).
- **Benefits Paid Limit:** a weekly or monthly limit.
- **Benefit Payout Method:** insurers pay LTCI benefits with an indemnity payment, or expense, incurred payment.
- **Inflation Protection Rider:** LTCI benefit payments remain the same without inflation protection.

LTCI Policy Payments (cont.)

- **Premium Payment:** premiums can be paid monthly, quarterly, semi-annually, or annually.
- **Tax-Qualified/Non-Tax Qualified:** in some cases, policyholders can include all or part of the premium as a Federal income tax deduction and may not be required to pay Federal taxes on the policy's benefit payments. Tax qualifications vary by state and policy.
- **Pooled Benefits or Joint Policies:** a joint LTCI policy that covers both people and has a lower premium than buying two separate policies.

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Other Factors to Consider for LTCI Policies

- Age
- Premium
- Pre-Existing Conditions
- Gender
- Financial Ratings Companies "Churning" People Between LTCI Plans
- Consumer Protections (such as outline of coverage, 30-day free look period, inflation protection, and guaranteed renewable).

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- Age: will not sell a policy to someone under age 18 or over age 85.
- Premium: premiums are based on age at purchase and scope of benefits.
- Pre-Existing Conditions
- Gender
- Financial Ratings Companies: before buying a policy, consumer should check an insurance company's current standing with the Kansas Insurance Department (http://www.ksinsurance.org/).
- "Churning" People Between LTCI Plans: occurs when an agent sells an LTCI policy to someone and then a few years later he/she returns to sell another policy. Insurance agents typically receive higher commissions in the first year that a policy is in force.
- Consumer Protections (such as outline of coverage, 30-day free look period, inflation protection, and guaranteed renewable).

Other Factors to Consider for LTCI Policies (cont.)

- Bed Hold
- Caregiver Training: benefit pays to train an informal (unpaid) caregiver to care for a person in their home.
- Emergency Response System
- Non-Forfeiture Benefits
- Restoration of Benefits
- Shared Care (also called Spousal Benefit Transfer
- Survivorship Benefit

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- **Bed Hold:** pay to hold bed in nursing home when person goes to the hospital for a specified number of days.
- **Caregiver Training:** benefit pays to train an informal (unpaid) caregiver to care for a person in their home.
- **Emergency Response System:** pays for an emergency response system (like the alert pendant advertised on television).
- **Non-Forfeiture Benefits:** the policy pays for a portion of benefits when the consumer can no longer afford to pay the LTCI premium.
- **Restoration of Benefits:** restore benefits to the original maximum amounts after a period (180 days) during which the insured person goes without treatment or services paid by the policy.
- **Shared Care (also called Spousal Benefit Transfer):** an insured spouse receives benefits under the other spouse's policy when they reach the maximum lifetime benefit in their own policy.
- **Survivorship Benefit:** when one spouse dies, no more premiums will be due on the surviving spouse's policy as long as no claims were paid by either policy during the first 10 years of concurrent coverage.

Kansas Partnership for Long-Term Care

- The *Kansas Partnership for Long-Term Care* is an initiative involving the State of Kansas and private insurance companies to encourage the private funding of long-term care.
- Requirements:
  - Policy must have been issued after April 1, 2007;
  - insured must have been a Kansas citizen at the time of issue; policy must be tax qualified;
  - policy must contain certain consumer protection provisions;
  - policy must provide minimum inflation protection.
- To learn more, go to http://www.ksinsurance.org/ltc/index.htm, or call the Kansas Insurance Department.

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- The *Kansas Partnership for Long-Term Care* offers a way for Kansans to protect their assets if they ever need to apply for Medicaid services.
- It is an initiative involving the State of Kansas and private insurance companies to encourage the private funding of long-term care. If a person purchases qualified long-term care insurance and uses the benefits under the policy, they can keep assets equal to the benefits received if that person applies and is approved for Medicaid.
- Requirements: Policy must have been issued after April 1, 2007; insured must have been a Kansas citizen at the time of issue; policy must be tax qualified; policy must contain certain consumer protection provisions; and policy must provide minimum inflation protection.
- To learn more, go to http://www.ksinsurance.org/ltc/index.htm, or call the Kansas Insurance Department.

Resources for LTCI Counseling

- Self-Assessment Tool: Individuals must make decision to purchase LTCI when they are still relatively healthy. People need to know (1) if their financial situation requires they will need LTCI, and (2) if they will be able to afford it.
- *Kansas Long-Term Care Insurance and Shopper's Guide* available through Kansas Insurance Department, www.ksinsurance.org/ltc.
- *Long-Term Care Insurance: Is it Right for You?* is a fact sheet available on AARP's website, http://www.aarp.org.
- Visit the National Clearinghouse for Long-Term Care Information website, administered by the Administration on Aging (AoA), http://www.longtermcare.gov/LTC/Main_Site/index.aspx for resources to help with long-term care planning.

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What is a QIO?

- Led by CMS, the QIO program is one of the largest Federal programs dedicated to improving quality at the local level.
- They contract with CMS to investigate complaints about poor care, review hospital discharge decisions, and handle expedited review requests for skilled nursing facility and home health service terminations.
- QIOs work with local healthcare providers, serving as change agents, conveners, and collaborators.
- QIOs work with local healthcare providers, conveners, and collaborators. They form groups of healthcare providers and other stakeholders to learn from one another, making care more patient-centered, safer, and coordinated.
- Providers benefit from the experience of their peers across the country, which further accelerates improvement.

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Led by CMS, the QIO program is one of the largest Federal programs dedicated to improving quality at the local level.
It is the cornerstone of Medicare's efforts to improve the quality and value of healthcare for over 52 million beneficiaries.

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Providers benefit from the experience of their peers across the country, which further accelerates improvement.

What Has Changed in the QIO Program?

- CMS has awarded 53 contracts where each QIO performs both case review and quality improvement support for each state or territory.
- In August 2014, CMS restructured the program.
- In the new structure, case review and quality improvement functions are preformed by different contractors, the contract periods are extended from 3 to 5 years, and there is enhanced focus on learning, collaboration, and dissemination of best practices.

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What Has Changed in the QIO Program? (cont.)

The following QIOs are contracted in each state:
- BFCC-QIOs manage all beneficiary complaints and quality of care reviews to ensure consistency in the review process while taking into consideration local factors important to beneficiaries and their families.
- Quality Innovation Network (QIN) QIOs are responsible for working with providers and communities on data-driven quality initiatives to improve patient safety, reduce harm, and improve clinical care and transparency at local, regional, and national levels. For additional information, visit www.qionews.org.

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How Does This Change Affect Providers?

- Provider's QIO contact for Medicare discharge appeals and quality of care concerns is KEPRO.
- "Notice of Medicare Non-Coverage" forms and any other internal or external documents or resources that list the WIO's information need to be updated with KEPRO's contact information.
- In order to participate in the Medicare program, Federal law requires certain providers to have a Memorandum of Agreement (MOA) with a QIO. MOAs outline the QIO's and provider's responsibilities during the review process. Visit www.keproqio.com for MOA information and forms.

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KEPRO

- KEPRO works under contract with CMS. It serves as the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for CMS Areas 2, 3, and 4. Kansas is in Area 4.
- It manages all beneficiary complaints and quality of care reviews to ensure consistency in the review process.
- Case review services are free for all people with Medicare.
- It also reviews discharge appeals when Medicare beneficiaries do not feel they are ready for discharge from the hospital or skilled services.

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It manages all beneficiary complaints and quality of care reviews to ensure consistency in the review process.

Case review services are free for all people with Medicare.

It also reviews discharge appeals when Medicare beneficiaries do not feel they are ready for discharge from the hospital or skilled services.

How Can a Medicare Beneficiary Contact KEPRO?

- KEPRO is available to assist Medicare beneficiaries who have questions about whether they are ready for discharge from a hospital or home health agency, or whether they received appropriate care.
- Medicare beneficiaries should contact (855) 408-8557 (toll-free) or (813) 280-8256.
  - The Helpline is available Monday through Friday from 9am to 5pm, and from 11am to 3pm on Saturday, Sunday, and holidays.

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CMS Program Resources

- Identify CMS program-related resources
- Refer to Social Security's resources
- Review regulations
- Use resources to help with questions and issues

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- Use resources to help with questions and issues

CMS and Social Security have websites with important information.
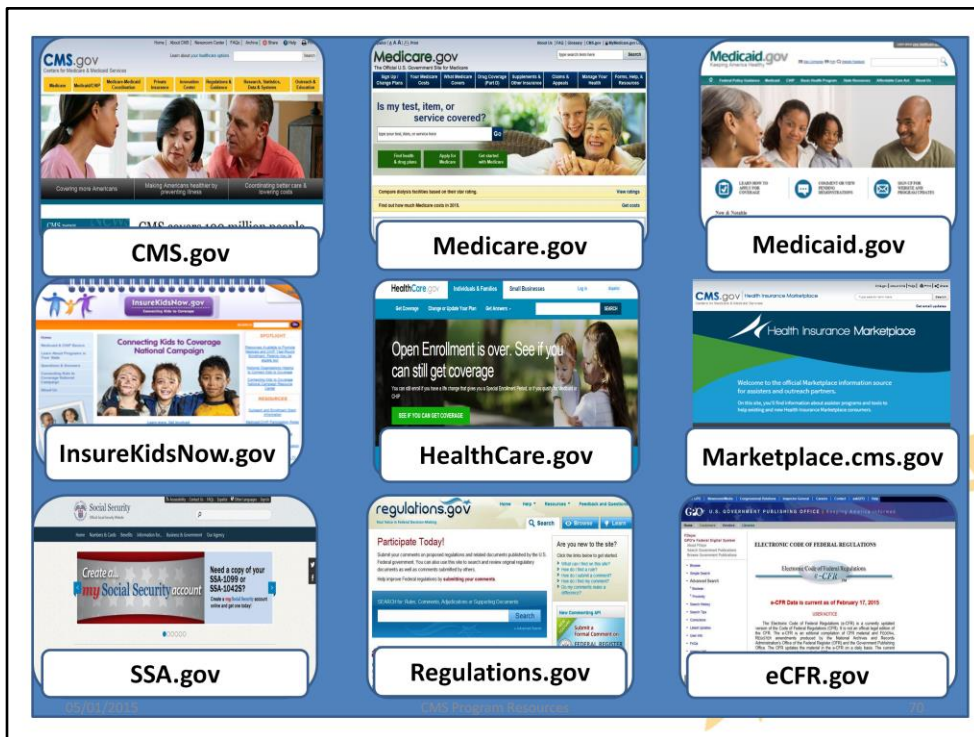
These websites have information you may need to help counsel a person with coverage from Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or through the Federally-facilitated Health Insurance Marketplace.

1. CMS.gov/ provides information on CMS's programs for providers, partners, and researchers.

2. Medicare.gov/ provides information on the Medicare program for people with Medicare.

3. Medicaid.gov provides information on the Medicaid program. It provides referrals to specific states since Medicaid is a joint federal/state program.

4. InsureKidsNow.gov/ is the website for coverage for teens and children in limited income and resource households from the Children's Health Insurance Program.

5. HealthCare.gov/ is the website for the Federally-facilitated Health Insurance Marketplace. This site will refer you to states that have State-based Marketplaces.

6. Marketplace.cms.gov/ is the website for partners and stakeholders to get information and training on the Marketplace.

7. SSA.gov provides information on a broad range of Social Security benefits and enrollment in the Medicare program.

8. Regulations.gov is the federal regulations website.

9. eCFR.gov/cgi-bin/ECFR?page=browse is the electronic Code of Federal Regulations website.

Let's look at each site.

CMS.gov

- Official website for the Centers for Medicare & Medicaid Services (CMS)
  - Primarily for partners, providers, researchers, etc.
- You can use the website to
  - Access training materials and schedules
  - Research issues using CMS manuals and guidance
  - Find details about what Medicare covers

CMS Program Resources 71

CMS.gov is the official website for the Centers for Medicare & Medicaid Services (CMS). The content is used primarily by partners, providers, researchers, etc.

You can use the website to

- Access the CMS National Training Program (NTP) webpage and training library.

- Get Medicare Learning Network (MLN) Resources, which is the official CMS educational products and information source for Medicare Fee-For-Service (FFS) Providers.

- Research issues using CMS manuals and guidance which offer day-to-day operating instructions, policies, and procedures based on statutes and regulations, guidelines, models, and directives.

- Find details about what Medicare covers.

Let's look at each tab to see the specifics of what information is provided.

This is the CMS.gov/ homepage. You can navigate the website using the yellow tabs at the top of the page to view information on Medicare, Medicaid, the Children's Health Insurance Program, Medicare-Medicaid Coordination, the Health Insurance Marketplace and Affordable Care Act, Health Care Innovations, Regulations and Guidance, Research including statistics and data, and Outreach and Education.

At the top of the page you can also access the Newsroom to see press releases. And, there is access to Frequently Asked Questions (FAQs). This is a great resource to use when you have a specific question.

Let's take a look at the information provided on each tab.

Medicare

The Medicare tab outlines the information available regarding multiple aspects of the Medicare program. Use this page to get details by topic, including general information, appeals and grievances, billing, and more. You can get information on Original Medicare, Medicare Advantage, and Medicare drug coverage.

Eligibility and Enrollment Guidance

E-Health

CMS issues guidance to outline who's eligible to enroll in Medicare plans, when and how they're able to enroll and disenroll, and more

E-Health

E-Prescri

Electronic

Personal

Eligibility and Enrollment

Low Income Subsidy for Medicare Prescription Drug Coverage

Medicare Managed Care Eligibility and Enrollment

Medicare Prescription Drug Eligibility and Enrollment

Original Medicare (Part A and B) Eligibility and Enrollment

Medicare & the Marketplace

Survey & Certification - Certification & Compliance

Survey & Certification - Emergency Preparedness

Survey & Certification - Enforcement

Survey & Certification - Guidance to Laws & Regulations

Survey & Certification - Promising Practices Project

Survey & Certification - Surveyor Training

Nursing Home Quality Assurance & Performance Improvement

Quality Initiatives/Patient Assessment Instruments

Quality Initiatives - General Information

ASC Quality Reporting

Electronic Prescribing Incentive Program

Home Health Quality Initiative

CMS Program Resources   74

Still on the Medicare tab, but scrolling down the page, another web resource partners use frequently is the guidance that CMS releases to explain eligibility, enrollment, and disenrollment for Original Medicare, Medicare Advantage Plans, and Medicare Prescription Drug Plans. This guidance outlines who's eligible to enroll in Medicare plans, when and how they're able to enroll and disenroll, and more.

The guidance documents are found in the Eligibility and Enrollment section. Then, click on the link you need to research.

Medicare Coverage Database

You can get to the Medicare Coverage Database (MCD) through the link in the Top 5 Resources section of the CMS.gov home page. The searchable MCD contains all Medicare National Coverage Determinations (NCDs), National Coverage Analyses (NCAs), Local Coverage Determinations (LCDs), and local articles. NCAs include proposed NCD decisions. You can use MCD to find out details about what services and procedures Medicare covers.

The Social Security Act is the primary authority for all coverage provisions and subsequent policies. Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury and within the scope of a Medicare benefit category. LCDs are the vast majority of Medicare coverage determinations. In certain cases, however, Medicare deems it appropriate to develop an NCD for an item or service to be applied on a national basis for all Medicare beneficiaries meeting the criteria for coverage.

The national coverage information in the MCD is updated in real time, except the national coverage download, which is updated weekly. The local coverage information is updated on a weekly basis, usually on Thursdays. Subscribers to the CMS Coverage electronic mailing list receive weekly notification when national coverage documents are updated. To join, enter your email address in the Receive Email Updates section on the bottom of the MCD webpage.

National Coverage Determinations (NCDs) describe the circumstances for Medicare coverage nationwide for a specific medical service, procedure, or device. NCDs generally outline the conditions for which a service is considered to be covered, or not covered, under §1862(a)(1) or other applicable provisions of the Social Security Act.

National Coverage Analyses (NCAs) include numerous documents that support the national coverage determination process. They include tracking sheets to inform the public of the issues under consideration and the status of the review, Technology Assessments, and Decision Memoranda that announce CMS' intention to issue an NCD. These documents, along with the compilation of medical and scientific information currently available, any Food and Drug Administration (FDA) safety and efficacy data, clinical trial information, etc., provide the rationale behind the evidence-based NCDs.

Medicaid/CHIP

CMS Program Resources

The next tab on the CMS.gov webpage is Medicaid/CHIP. When you select this tab you will be taken to Medicaid.gov which is the official U.S. Government site for Medicaid.

You can use the website to

- Read federal policy guidance

- Find Medicaid and CHIP information by state, topic, or population

- Access the State Resource Center

- Learn how the Affordable Care Act impacts Medicaid and CHIP

Medicare-Medicaid Coordination

CMS Program Resources

If you'd like to learn about how Medicare coordinates with Medicaid, you can click on the Medicare-Medicaid Coordination link. There is also a listserv link you can access and join for updates. Click the circled Medicare-Medicaid Coordination Office hyperlink and scroll down the webpage.

Advancing Care for People with Medicaid and Medicare

The Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) serves people who are enrolled in both Medicare and Medicaid, Medicare-Medicaid enrollees, also known as dual eligibles. Their goal is to make sure Medicare-Medicaid enrollees have full access to seamless, high quality health care and to make the system as cost-effective as possible.

The Medicare-Medicaid Coordination Office works with the Medicaid and Medicare programs, across Federal agencies, States and stakeholders to align and coordinate benefits between the two programs effectively and efficiently. They partner with States to develop new care models and improve the way Medicare-Medicaid enrollees receive health care.

Private Insurance

CMS.gov
Centers for Medicare & Medicaid Services

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Learn about your healthcare options

Search

Medicare | Medicaid/CHIP | Medicare-Medicaid Coordination | Private Insurance | Innovation Center | Regulations & Guidance | Research, Statistics, Data & Systems | Outreach & Education

CCIIO Home > Consumer Information and Insurance Oversight

CCIIO

The Center for Consumer Information & Insurance Oversight

Programs and Initiatives

Consumer Support and Information

Health Insurance Market Reforms

Health Insurance Marketplaces

Insurance Programs

Other Insurance Protections

Premium Stabilization Programs

Resources

Consumer Information and Insurance Oversight

Ensuring the Affordable Care Act Serves the American People

The Center for Consumer Information and Insurance Oversight (CCIIO) is charged with helping implement many reforms of the Affordable Care Act, the historic health reform bill that was signed into law March 23, 2010. CCIIO oversees the implementation of the provisions related to private health insurance. In particular, CCIIO is working with states to establish new Health Insurance Marketplaces.

CCIIO works closely with state regulators, consumers, and other stakeholders to ensure the Affordable Care Act best serves the American people.

Marketplace Resources

- Further information for partners is available on the CMS Health Insurance Marketplace website.

Updates

May 29, 2015
CMS Bulletin on Proposed Out-Of-Pocket (OOP) Cost Comparison Tool for the Federally-facilitated Marketplaces (FFMs)

March 24, 2015
Vendors of FFM Training and Information Verification for Agents and Brokers – Plan Year 2016 Application

February 20, 2015
HHS Notice of Benefit and Payment Parameters for 2016

February 20, 2015
2016 Letter to Issuers in the Federally-facilitated Marketplaces

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The Private Insurance tab takes you to the Center for Consumer Information and Insurance Oversight's (CCIIO's) homepage. CCIIO is charged with helping implement many reforms of the Affordable Care Act. Here you can find out information about programs and initiatives, as well as Health Insurance Marketplace resources. Marketplace Resources directs you to Marketplace.cms.gov for information and training for partners. Locate consumer-friendly information about new coverage options and apply for coverage through the Health Insurance Marketplace at HealthCare.gov.

The Center for Medicare & Medicaid Innovation (CMMI), sometimes called the Innovation Center, supports the development and testing of innovative health care payment and service delivery models. If you'd like to learn about new CMS innovations, you can use this tab to find out about innovations in specific states as well as milestones and updates.

At any given time, there are numerous models in various stages of development. You may search and view the most current information on the Innovation Center's website. Examples of Ongoing Models include:

- Pioneer Accountable Care Organization (ACO) Model- rewarding 19 groups of health care providers working together to coordinate care

- Rural Community Hospital Demonstration- testing the feasibility and advisability of providing reasonable cost reimbursements for small rural hospitals

- Bundled Payments for Care Improvement- bundles payment for an episode of care

- Comprehensive Primary Care Initiative- multi-payer initiative providing financial support to primary care practices in 7 markets

- Strong Start for Mothers and Newborns Initiative: Enhanced Prenatal Care Models- tests 3 evidence-based maternity care service approaches to improve the health outcomes of pregnant women and newborns

Regulations & Guidance

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Regulations & Guidance

Guidance

Advisory Committees

CMS Records Schedule

CMS Small Business Administration Ombudsman

CMS Small Entity Compliance Guides

Executive Order Guidance

Manuals

Privacy Act System of Records

Privacy Office

Rulings

Transmittals

HIPAA Administrative Simplification

Legislation

Clinical Laboratory Improvement Amendments (CLIA)

Conditions for Coverage (CfCs) & Conditions of Participations (CoPs)

Deficit Reduction Act

Economic Recovery Act of 2009

EHR Incentive Programs

Emergency Medical Treatment & Labor Act (EMTALA)

Freedom of Information Act (FOIA)

Legislative Update

Paperwork Reduction Act (PRA) of 1995

Section 1011 - Emergency Health Services Furnished to Undocumented Aliens

Open Payments

CMS news

Departments of Justice and Health and Human Services announce over $27.8 billion in returns from joint efforts to combat health care fraud

Affordable Care Act initiative builds on success of ACOs

CMS issues the final HHS Notice of Benefit and Payment Parameters for 2016

CMS proposes 2016 payment and policy updates for Medicare Health and Drug Plans

CMS Strengthens Five Star Quality Rating System for Nursing Homes

View more news & links ▶

CMS Program Resources   80

If you'd like to access CMS manuals, regulations or guidance, you can click on the Regulations and Guidance tab.

CMS Program Resources

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The CMS Online Manual System, on the Regulations & Guidance tab, is used by CMS staff, partners, contractors, and State Survey Agencies to administer CMS programs. It offers day-to-day operating instructions, policies, and procedures based on statutes and regulations, guidelines, models, and directives.

The CMS manuals are among the most frequently-accessed resources on the CMS website. As such, you'll also find a link to the manuals in the Top 5 Resources section of the CMS homepage.

CMS Manuals Continued

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Centers for Medicare & Medicaid Services

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| Medicare | Medicaid/CHIP | Medicare-Medicaid Coordination | Insurance Oversight | Innovation Center | Regulations and Guidance | Research, Statistics, Data and Systems | Outreach and Education |

Home > Regulations and Guidance > Manuals > Manuals

Manuals

Future Updates to the IOM

Internet-Only Manuals (IOMs)

Paper-Based Manuals

Manuals

The CMS Online Manual System is used by CMS program components, partners, contractors, and State Survey Agencies to administer CMS programs. It offers day-to-day operating instructions, policies, and procedures based on statutes and regulations, guidelines, models, and directives. In 2003, we transformed the CMS Program Manuals into a web user-friendly presentation and renamed it the CMS Online Manual System.

Related Links

Transmittals

Quarterly Provider Updates

CMS Forms

Page last Modified: 04/05/2012 9:41 AM
Help with File Formats and Plug-Ins

Click on the IOM link to access CMS manuals

From the manuals page, you'll need to click the link on the left that says Internet-only Manuals (IOMs).

Internet-Only Manuals (IOMs)

There are 25 Internet-only manuals covering many Medicare and Medicaid-related topics.

For instance, if you're interested in learning whether or not Medicare Part A will pay for a private hospital room, you'd start by clicking on the Medicare Benefit Policy Manual, which includes details about Medicare Part A and B covered services.

100 Introduction
100-01 Medicare General Information, Eligibility and Entitlement Manual
100-02 Medicare Benefit Policy Manual
100-03 Medicare National Coverage Determinations (NCD) Manual
100-04 Medicare Claims Processing Manual
100-05 Medicare Secondary Payer Manual
100-06 Medicare Financial Management Manual
100-07 State Operations Manual
100-08 Medicare Program Integrity Manual
100-09 Medicare Contractor Beneficiary and Provider Communications Manual
100-10 Quality Improvement Organization Manual
100-11 Programs of All-Inclusive Care for the Elderly (PACE)Manual
100-12 State Medicaid Manual (The new manual is under development)
100-13 Medicaid State Children's Health Insurance Program (Under Development)
100-14 Medicare ESRD Network Organizations Manual
100-15 Medicaid Integrity Program (MIP)
100-16 Medicare Managed Care Manual
100-17 CMS/Business Partners Systems Security Manual
100-18 Medicare Prescription Drug Benefit Manual
100-19 Demonstrations
100-20 One-Time Notification
100-21 Recurring Update Notification
100-22 Medicare Quality Reporting Incentive programs Manual
100-24 State Buy-In Manual
100-25 Information Security Acceptable Risk Safeguards Manual

Internet-Only Manuals (IOMs) Continued

Each manual is broken up into different chapters, according to topic.

In this case, since the information we're looking for is about Part A-covered hospital accommodations, we'd click on the first blue link for Chapter 1: Inpatient Hospital Services Covered Under Medicare Part A.

The CMS Data Navigator is found on the Research, Statistics, Data & Systems tab.

The CMS Data Navigator application is an easy-to-use, menu-driven search tool that makes CMS' data and information resources easier to search and access. Use the Data Navigator to find data and information products for specific CMS programs, such as Medicare and Medicaid, or on specific health care topics or settings-of-care.

You can also find statistics, trends & reports, computer data & systems, and research that includes quantitative information on CMS programs.

CMS National Training Program

To locate our training materials, go to CMS.gov, click on Outreach and Education, and click on Get Training.

CMS National Training Program

You'll see 3 options. The first is the Medicare Learning Network (MLN). They're responsible for provider training. MLN's Catalog of Products is a free interactive downloadable document that lists all MLN products by media format. To access the catalog, scroll to the "Downloads" section and select "MLN Products Catalog." Once you have opened the catalog, you may either click on the title of a product or click on the type of "Formats Available." This will link you to an online version of the product or the Product Ordering Page.

MLN Product Ordering page - allows you to order hard copy versions of many of our products. To access the MLN Product Ordering page, scroll to the "Related Links Inside CMS" and select "MLN Product Ordering Page." The MLN Publications List contains the electronic versions of the downloadable publications. These products are available to you free of charge. To access the MLN Publications go to the left hand column on the page and select "MLN Publications." You will then be able to sort by date/year, topic, title, or format. You may also search by the date an item was last modified, a topic, or key word.

The second option is the CMS National Training Program. We develop training materials for our partners and stakeholders who counsel people with Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Last, you can access training materials on the Federally-facilitated Health Insurance Marketplace.

CMS National Training Program

We provide support for partners and stakeholders, not-for-profit professionals and volunteers who work with seniors and people with disabilities, and others who help people make informed health care decisions.

Resources are provided in formats to meet specific needs:

Training Library: A comprehensive collection of training resources, including training presentations, workbooks, job aids, and other learning tools.
Web-based Training : Our Learning Series webinars provide an in-depth overview of a key topic each month. The CMS Stakeholder & Partner Education monthly webinar features CMS policy experts who provide in-depth information on current issues.
Multimedia Products: Entertaining and informative outreach and education tools featuring videos, webinars, and webcasts. Some products are available in Spanish.
Classroom Modules: Complex information is made easy-to-understand in these comprehensive, customizable train-the-trainer presentations that include slides and speaker's notes.
Training Workshops: These face-to-face sessions are held nationwide for partners who train others. They feature expert Medicare presenters and interactive learning activities.
Use these products and resources to learn about Medicare, Medicaid, and the Children's Health Insurance Program. The National Training Program also provides information on the Health Insurance Marketplace on Marketplace.cms.gov. This information will help you conduct outreach and education sessions, or counsel people on their health care options and benefits.

Our materials are listed on the left hand side of the page.

You can sign up for the listserv by clicking on "Join the CMS National Medicare Training Program E-Mail List." Those on our listserv receive monthly updates and information on upcoming training.

Medicare.gov

- Official U.S. Government site for Medicare
  - Primarily for people with Medicare and their caregivers
- You can use the website to
  - See what is covered
  - Compare Medicare health and drug plans
  - Find a doctor, provider or supplier
  - Compare the quality of health care providers
  - Order publications or view them online
  - Find helpful contact information
  - Sign up for MyMedicare.gov

CMS Program Resources

89

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  - Order publications or view them online

  - Find helpful contact information

  - Sign up for MyMedicare.gov

The Medicare.gov website has many enhanced features such as

- Research-based web best practices

- Multiple paths to allow users to complete top tasks with ease

- Improved information delivery to be consistent across communication channels (e.g., publications, websites, call center, etc.)

- Expanded information architecture to make all consumer content available online (e.g., Medicare & You)

- Allows personalization wherever possible

- Enhanced search functionality

In addition to the many established helpful functions, the enhanced website features were included based on data and research, including Medicare.gov web analytics (statistics), results from Medicare.gov user surveys, top questions asked of 1-800-MEDICARE, top publication requests, and years of testing data on the Medicare & You handbook, our websites, and other products.

Usability testing is done to confirm that users understand and are able to successfully navigate the website. Based on research, we've created multiple paths to top tasks, like cost, coverage, enrollment, and finding plans. We also used action-oriented labels and text that is heavily loaded with key words drawn from consumer testing.

Additionally, the website has a responsive design for tablets and mobile devices. Its layout allows over 80% of visitors to self-service directly from the home page. The home page also includes a dedicated area to highlight critical or upcoming initiatives, which was strategically placed so that it doesn't interfere with the top tasks, yet still appear on the screen without the need to scroll.

Find a Doctor, Provider, or Supplier

Using the Find doctors, providers, hospitals, plans & suppliers section of the page, you can access tools to help you

- Get contact information for hospitals, doctors, nursing homes, home health agencies, dialysis facilities, and suppliers

- Compare information about the quality of care and services these providers offer

- Get helpful tips on what to look for when comparing and choosing a provider

NOTE: Using the Find-a-Doctor/Physician Compare tool, you can view information by location about Medicare-enrolled doctors. Some of these doctors may accept assignment, while others may not. Assignment is an agreement by a doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill for any more than the Medicare deductible and coinsurance. **You can refine your search to view only doctors who accept assignment.** Also, some doctors may be accepting new patients, while others may not. Call the doctor for more information.

Medicare Plan Finder

From the Medicare.gov homepage, click on the Find Health and Drug Plans link to go to the Medicare Plan Finder homepage. Plan Finder takes you through several screens to help you refine your selection to help you make an informed decision.

NOTE: For more Plan Finder information including video tutorials, visit the Plan Finder Toolkit at CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/T raining-Library-Items/CMS1239988.html?DLPage=1&DLFilter=plan&DLSort =0&DLSortDir=ascending.

Forms, Help and Other Resources

Once you get to the publications page, you have the option of searching by keyword or publication number. You can also click on links to view the most popular Medicare publications and access several podcasts of Medicare information.

In this example the search shows results for "Medicare prescription drug coverage." All related publications will appear. Note that you will be given the option to select the language and order the publication in print if available, or read it online.

Partners can order multiple copies of available publications at productordering.cms.hhs.gov/. Topics include Medicare, Medicaid, CHIP, and the Health Insurance Marketplace. You may also have the opportunity to pre-order publications.

Find Helpful Contacts and Resources

For information about contacts in a particular geographical area, you should use the Helpful Contacts tool. When you click on the Help & Resources tab, you'll find a link (circled above) to helpful phone numbers and websites. You'll have the option to search by a specific organization (by name or state) or on a particular topic (e.g., general Medicare, billing, etc.).

The related websites section allows you to access other websites that can provide additional help or information that isn't presented on Medicare.gov. Below are some of the topics for websites you can link to

- Medicare Savings Program
- State Insurance Departments
- Senior Websites
- Other Government Websites
- Other Healthcare Choice Resources

Sign Up for MyMedicare.gov

MyMedicare.gov is an optional, free, and secure site designed to help you check the status of your eligibility, enrollment, and other Medicare benefits. It also lets you access your claims information almost immediately after your claims are processed by Medicare and provides your preventive health information 24 hours a day, seven days a week.

Getting started—Find information on how you can get started registering for your own MyMedicare.gov account. Learn about why it's important to set up an account, how to enter your information, and how to make changes to your information.

Account services —Get information about questions you may have about setting up your new account, including changing your username, what to do if you forget your password, and getting emails from Medicare.

Customer service —Find out who to contact if you need any help with your MyMedicare.gov account, including issues with registration, not getting your password letter, or if you're unable to register with MyMedicare.gov.

Security & privacy —Review the online policies about website security and privacy, rules and regulations for using MyMedicare.gov, including how Medicare protects your personal information using the latest in security software.

Virtual tour —MyMedicare.gov provides online video demonstrations for help with a number of topics related to the many functions and features of the MyMedicare.gov website.

You can share the demo Ids/password for practice on MyMedicare.gov. All Test Ids begin with MBPUSER + add 201a-209a, the password for all is CMSPWD2USE.

Registering lets you check your Original Medicare claims as soon as they are processed; find your eligibility, entitlement, and preventive service information; check your health and prescription drug enrollment information, as well as your Part B deductible information; manage your prescription drug list and personal health information, and more.

Information in Other Languages

You can get to this page by going to the bottom of the Medicare.gov homepage and clicking on "Information in Other Languages" in the "Take Action" section. Each language heading displays which specific publications are available in that language.

The link to this page is Medicare.gov/about-us/other-languages/ information-in-other-languages.html.

A video in American Sign Language (ASL) is available at youtube.com/watch?feature=player_embedded&v=eskZVAg7v0o. It provides an overview of Medicare, including Medicare Parts A, B, C and D; Medicare-covered preventive services, and the differences between the Medicare and Medicaid programs.

- Medicaid.gov is operated by the Centers for Medicare & Medicaid Services (CMS)
  - You can use the website to
    - Read federal policy guidance
    - Find Medicaid and Children's Health Insurance Program (CHIP) information by state, topic, or population
    - Access the State Resource Center
    - Learn how the Affordable Care Act impacts Medicaid and CHIP

HealthCare.gov

- Official U.S. government resource to help you take health care into your own hands
  - Includes reports, videos, blogs, and a newsroom
- You can use the website to
  - Sign up for health coverage
  - Find out about available insurance options
  - Get help using your insurance
  - Learn about the health care law

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HealthCare.gov is intended to reach the general public and contains information about the Affordable Care Act (ACA) and health insurance coverage options.

HealthCare.gov Homepage

HealthCare.gov is the official government website for the Federally-facilitated Health Insurance Marketplace. It will help you find the health insurance best suited to your needs, whether it's private insurance for individuals, families, and small businesses, or public programs that may work for you. It was created under the health insurance reform law, the Affordable Care Act, to help consumers.

HealthCare.gov/see-plans/ will ask you questions about your health insurance status, your age, any special medical needs, and then will provide you with a list of health insurance options that may help, such as getting a private health insurance plan, Medicaid, or health insurance through work. You can click on each of the options to get more details.

If your state has its own Marketplace, you will be directed to its website.

Partner Page for the Federally-Facilitated Health Insurance Marketplace

The third option on CMS.gov is for the Marketplace information for partners and stakeholders. However, you can reach it directly by going to Marketplace.cms.gov/.

You can get up-to-date information to help you counsel people who may benefit from the Heath Insurance Marketplace at Marketplace.cms.gov. There is access to consumer materials, training materials (including videos), research and more. You can sign up for updates as well. This is also where organizations can apply to become Certified Application Counselors and Champions for Coverage.

Training information for Navigators and Certified Application Counselors is accessible from this web page.

SSA.gov

- Official website of the U.S. Social Security Administration
- You can use the website to
  - Apply for benefits, including
    - Retirement, Medicare, Extra Help, and Disability
  - Order a replacement Medicare card
  - Research issues using SSA's online manuals

The website for the Social Security Administration contains information related to Medicare, Medicaid and the Children's Health Insurance Program (CHIP). Title 18 of the Social Security Act covers Medicare. Title 19 covers Medicaid. Title 21 covers the Children's Health Insurance Program (CHIP).

SSA.gov Homepage

Click on "Benefits" at the top, then "Medicare" to reach the Medicare page

Retire Online!
Our retirement expert tells you just how easy it is to apply online.

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Many of the links you may need are located in drop-down lists from tabs at the top, or from links in boxes on the bottom of the page. You can click on the "Benefits" tab at the top and a drop-down list of topics will appear. You can click on "Medicare" to view a variety of topics and services available from Social Security. From this homepage you can accomplish a wide variety of tasks and locate information. For instance, there are links here to apply for benefits, get a Social Security card, get forms or publications, and sign up to get your Social Security Statement online.

SSA.gov Homepage for Publications

my Social Security
Log in
Create an Account
Check out your *Social Security Statement*, change your address & manage your benefits.

Online Services
Whether you are applying for or receiving benefits, learn what you can do online.

Retirement Estimator
Calculate your benefits based on your actual Social Security earnings record & apply online.

Disability Facts
Learn more about the Faces and Facts of Disability.

Items of Interest

- (i) FAQs
- ☑ Application Status
- Calculators
- 📄 Forms
- ☁ Office Closings

- ▢ Social Security Number
- 14 Benefits Planner
- Publications
- ✎ Social Security Update
- 📞 Contact Us

Get a Publication

News

February 2, 2015
Social Security Announces ~~line Service for Replacement SSA-1099s

Feb~~ry 2, 2015
FY 2016 President's Budget Request

January 22, 2015
Social Security to Expand Field Office Hours Nationwide

December 19, 2014
Social Security Acting Commissioner Colvin Receives Honorary Degree

October 22, 2014

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At the bottom of the Social Security page, you'll see more links to important topics and ways to complete needed tasks. Many people find the "Publications" link helpful to access resources and important information by topic or publication number.

SSA.gov Publications Page

Search by publication number or title
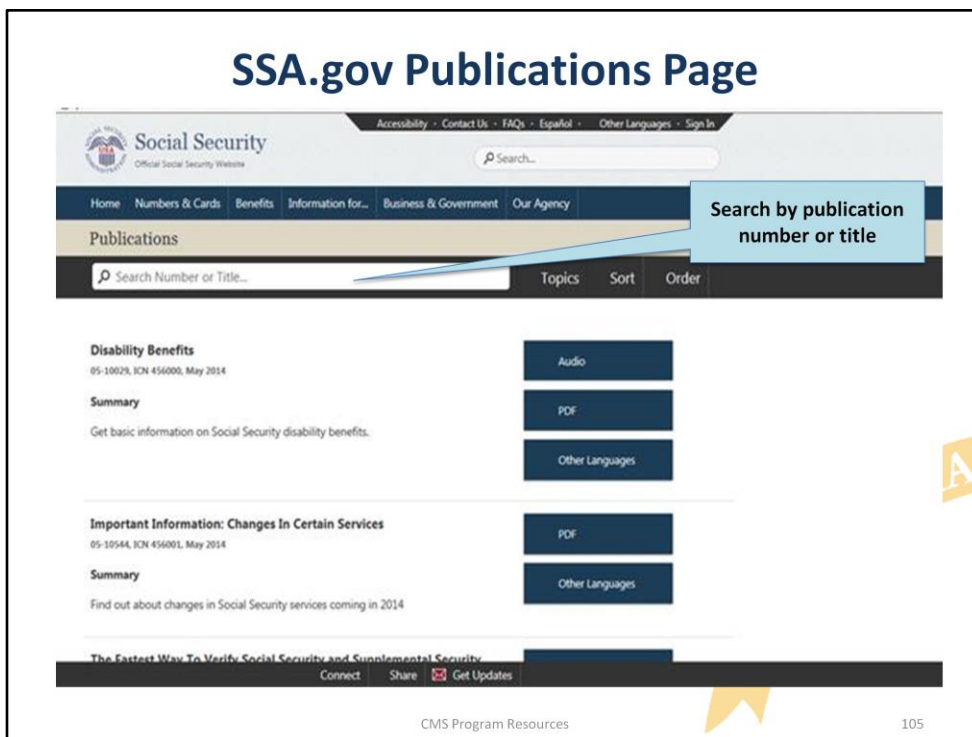
This is a view of the Social Security publications page. The top of the page has a field that allows you to enter the publication number or title of a publication that you're interested in finding. Next to the Search box is an option to browse publications by topic. As you scroll down the page, you'll notice format options listed to the right of each publication. You can access the information via audio file, .pdf, or in "Other Languages."

SSA's Medicare Tools
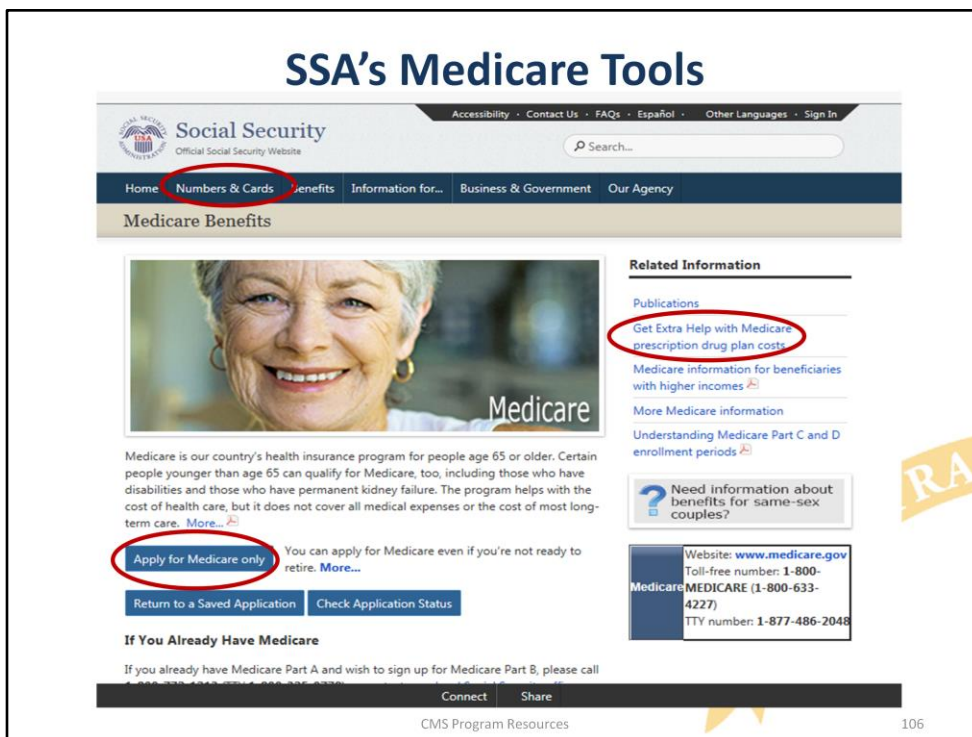
You can also access useful web tools by clicking on the Benefits tab at the top of the SSA homepage, then selecting Medicare from the drop-down list. Once on the Medicare Benefits page, you can apply for Medicare benefits, apply for Extra Help, check the status of your Extra Help application, or replace a lost, stolen, or damaged Medicare card.

- **Applying for Medicare** - Completing an application takes between 10 and 30 minutes, depending on the number of questions you need to answer. You can save your application as you go, so you can take a break and return at any time. You can also watch a video tutorial with helpful hints for completing the application.

- **Applying for Extra Help** - The application doesn't have to be completed all at once. After you fill in your name and address, you'll get a Re-entry Number. You'll be able to stop working on the application whenever you want, and then use this Re-entry Number to come back. When you've completed the application, you'll get a summary of the information you entered. You can make any necessary changes prior to submission. After you send the application to SSA electronically, you'll be able to print or save a receipt and your submitted application. There are time limits for your work on each page. You'll receive a warning after 25 minutes and you can extend your time on that page.

- **Replacing a Medicare Card** - If your Medicare card is lost, stolen or damaged, you can ask for a new one on this website. Your Medicare card will arrive in the mail in about 30 days. It will be mailed to the address Social Security has on file for you. If you need proof that you have Medicare sooner than 30 days, you also can request a letter which you'll receive in about 10 days. If you need proof immediately for your doctor or for a prescription, visit your nearest Social Security office.

Regulations.gov

- Source for U.S. Government Regulations from nearly 300 Federal agencies, including CMS
- You can use the website to
  - Review and submit comments on Proposed Rules
  - Read Final Rules
  - View Regulatory Agendas that list regulations each agency plans to issue

Pre Rule → Proposed Rule → Final Rule

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Regulations.gov is your source for information on the development of Federal regulations and other related documents issued by the U.S. Government. Through this site, you can find, read, and comment on regulatory issues that are important to you. The types of regulations that can be found on this site include Final Rules, Proposed Rules, and Notices from the Federal Register. Documents such as Public Comments and Supporting and Related Materials are often associated with these regulations, and can also be found on this site.

After Congressional bills become laws, Federal agencies are responsible for putting those laws into action through regulations. This process may include the following steps:

- An agency initiates a rulemaking activity, and adds an entry to its Regulatory Agenda (provides information about regulations the agency plans to issue or has recently completed)

- A Proposed Rule or other document is published to Regulations.gov

- The public is given the opportunity to comment on this rule for a specified timeframe

- Final Rules can be accessed on Regulations.gov

After final rules are published, CMS may issue updates to its operational manuals.

Regulations.gov Homepage

This is the Regulations.gov home page.

From here, you can either search by entering keywords into the Search box, or use the Advanced Search, as shown on the next slide.

You can also go to the Learn tab if you'd like to learn more about the regulatory process and each step in the rule-making process.

Let's say, for this example that we're specifically interested in reading the final rule that came out announcing changes to the Part C and Part D programs for 2013. We'd start by clicking on the Advanced Search button (circled above).

Advanced Search Page

Once you're on the **Advanced Search** page, you have many options. You can search by keyword, document type, date range, agency, and more.

For this example, we're going to use 3 filters – keyword, document type, and agency (all circled above). So, we'd type into the keyword box, select "Rule" as the document type, and choose CMS as the agency. Then, we'd click search and move on to the next page of search results.

eCFR.gov

- The Electronic Code of Federal Regulations (eCFR) is a current version of the Code of Federal Regulations (CFR)
  - Most up-to-date source for Medicare regulations
- You can use the website to
  - Find regulations after Final Rules are put in place

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The Electronic Code of Federal Regulations is the most up-to-date place to find Medicare information. Rule-making is constantly changing and as such, this website is updated on a daily or weekly basis. In contrast, CMS guidance and manuals may only be updated on an annual or bi-annual basis.

The Electronic Code of Federal Regulations is categorized by agency and title. Medicare is Title 42.

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Chapter 4 contains Medicare information - volumes 2, 3 and 4.

SUBCHAPTER A — GENERAL PROVISIONS (Parts 400 to 403)

SUBCHAPTER B — MEDICARE PROGRAM (Parts 405 to 426) (see handout for this section)

SUBCHAPTER C — MEDICAL ASSISTANCE PROGRAMS (Parts 430 to 456)

SUBCHAPTER D — STATE CHILDREN'S HEALTH INSURANCE PROGRAMS (SCHIPs) (Parts 457 to 457)

SUBCHAPTER E — PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) (Parts 460 to 460)

SUBCHAPTER F — QUALITY IMPROVEMENT ORGANIZATIONS (Parts 475 to 481)

SUBCHAPTER G — STANDARDS AND CERTIFICATION (Parts 482 to 498)
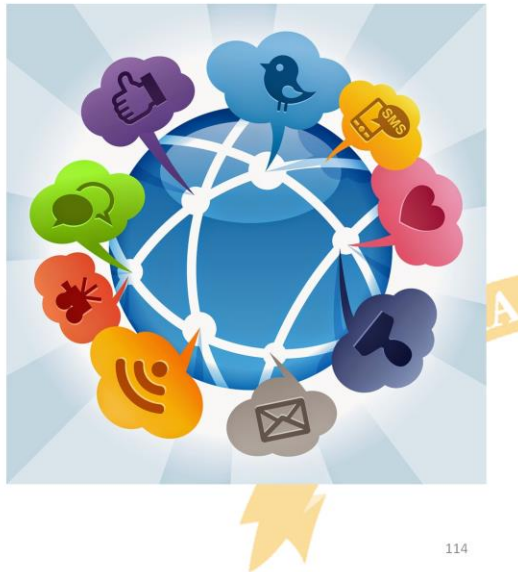
SUBCHAPTER H — HEALTH CARE INFRASTRUCTURE IMPROVEMENT PROGRAM (Parts 505 to 505)

Use the subchapters to find specific topics. For example, if you were looking for Medicare Advantage, you would find it under Part 422. You would find Part D under Part 423.

It's important that you're using the most up-to-date information when making decisions about health care. You can be sure to stay connected and receive current alerts and updates through email listservs and social media platforms.

Social Media

- CMS has a Medicare presence on
  - You Tube - CMSHHSgov YouTube.com/CMSHHSGov
  - Twitter at Twitter.com/CMSGov Our ID: @CMSGov
  - Linkedin
  - facebook.com/Medicare.gov
- CMS has a Marketplace presence on
  - facebook.com/HealthCare.gov
  - mobile.twitter.com/HealthCareGov
  - youtube.com/playlist?list=PLaV7m2-zFKpgZDNCz7rZ3Xx7q2cDmpAm7

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In addition to government websites, you may also use social media sites to get information about Medicare and the Marketplace. The 4 social media sites used by CMS to distribute information are YouTube, Linkedin and Twitter. Medicare also just joined Facebook at facebook.com/Medicare.gov. Information is also available on the Marketplace on Facebook, Twitter, and YouTube. You can use these sites to see informative videos about CMS-managed programs and learn about upcoming events.

Upcoming Important Dates and Reminders

By September 30, 2015 beneficiaries should receive:

Plan Annual Notice of Change (ANOC) and Evidence of Coverage.

People will get a notice from their current Medicare Part D Prescription Drug plan outlining 2016 formulary, benefit design, and/or premium changes.

Encourage beneficiaries to READ this notice!

LIS Rider

All people who qualify for Extra Help will get an LIS rider from their plan telling them how much help they'll get in 2016 towards their Part D premium, deductible, and copayments.

Upcoming Important Dates and Reminders

Also by September 30, 2015 beneficiaries should receive notification from Employer/Union and other group health plans that must tell all Medicare-eligible enrollees whether or not their drug coverage is creditable.

Late September, Medicare beneficiaries should start receiving their Medicare and You 2016 handbook.

October 1, 2015 Plans begin sending marketing material for Medicare Part C and Part D Open Enrollment.

Early October beneficiaries whose 2015 plan is leaving the Medicare program in 2016 will receive notices from their plan.

Upcoming Important Dates and Reminders

Late October, Consistent Poor Performer Notices will be sent to people enrolled in a poor performing plan. This year these notices will be important as they will indicate if the plan can continue on or must leave the Medicare market.

Open Enrollment Period

October 15 through December 7, 2015

Beneficiaries are encouraged to review their current Medicare Part D and Part C plans to make sure they want to keep the coverage they have or change to a different plan.

Changes to plans will take effect January 1, 2016.

Presentation Resources

- Medicare Access and CHIP Reauthorization Act (MACRA) Medicare Provisions
  - Santana, David, CMS, "Current Topics Presentation," 2015 CMS National Training Program (NTP) Workshops, August 10-11, 2015, St. Louis, MO.

- Medicare Improvements for Patients and Providers Act (MIPPA)
  - NCOA Center for Benefits Access, "MIPPA IV at a Glance."

- Health Insurance Portability and Accountability Act (HIPAA)
  - U.S. Department of Labor, Employee Benefits Security Administration, "Fact Sheet: The Health Insurance Portability and Accountability Act (HIPAA)," December 2004.

- SHICK Counselor Information

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Presentation Resources

- Moving From Affordable Care Act (ACA) to Medicare

  - Kaiser Health News, www.khn.org/news/

  - The Affordable Care Act & Medicare, www.medicare.gov/about-us/affordable-care-act/affordable-care-act.html

  - CMS, "The Affordable Care Act: A Stronger Medicare Program," www.CMS.gov/Outreach-and-Education/Training/CMSNational TrainingProgram/index.html

  - CMS, "Medicare and the Marketplace," www.CMS.gov/Outreach-and-Education/Training/CMSNational TrainingProgram/index.html

- Moving From Employer Health Coverage to Medicare

  - Make Medicare Work Coalition, "Medicare and Employer-Based Coverage – The Basics"

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Presentation Resources

- Long-Term Care
  - SHICK Handbook, "Chapter 10 – Long-Term Care Options," pp. 10-1 to 10-14.

- Quality Improvement Organizations (QIOs)
  - Information from KEPRO, www.keproqiocom

- CMS Program Resources
  - CMS, 2015 National Training Program, "Module 8 – CMS Program Resources," www.CMS.gov/Outreach-and-Education/Training/CMSNational TrainingProgram/index.html

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Other Helpful Resources

- SHICK State Office
  - Kim Evans, M.S. - SHICK Education and Outreach Coordinator
    - 785-296-6448
    - SHICK Training
    - SHICK Counselor Support
    - SHICK Partner Liaison
  - Janet Boskill - SHICK Program Administrator
    - 785-296-6319
    - CMS Reporting
    - SHICK Counselor Support
    - SHICK Training Support

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Training Information Exam

The final step of this training is completion of the 40-question test. Keep this document open to review the course as you take the Exam. Remember that the document is searchable through the Find function in Adobe.

The test is available at https://kdads.ks.gov/shick-training-courses---annual-update, either online through the online test form https://kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick/shick-coordinator-counselor-information/shick-training-courses---annual-update/course-7-annual-update-online-test---2015 or the PDF-formatted test on the Annual Update page.

If you choose to complete the test manually, please fax or email to:

Attn: Janet Boskill
Janet.Boskill@kdads.ks.gov
Fax: (785) 296-0256

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The final step of this training is completion of the 40-question test. Keep this document open to review the course as you take the Exam. Remember that the document is searchable through the Find function in Adobe.

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